COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

Meeting Minutes
10-12-2015

Commissioners Present: Bill Lindsay (chair), Cindy Sovine Miller, Elisabeth Arenales, Sue Birch, Jeff Cain, Rebecca Cordes, Greg D'Argonne, Steve ErkenBrack, Ira Gorman, Linda Gorman, Marcy Morrison, Dorothy Perry, Marguerite Salazar, Christopher Tholen, Jay Want
Staff: Lorez Meinhold and Cally King (Keystone)

Meeting Notes:

I) Approval of the Minutes

A) Dorothy Perry provided motion to approve the meeting minutes from September 25th; seconded by Elisabeth Arenales.

B) There were no changes and no objections to adopting the minutes.

II) Payment and Delivery Reform Presentation – Jay Want and Ira Gorman

A) Commissioners Jay Want and Ira Gorman provided a presentation on the Payment and Delivery System Reform topic area. See the Commission website for the full presentation.

B) Commission discussion:

1) An issue with price bundling is that there are huge variations in the price of items like implants for hip and knee replacement surgeries. Physicians are usually trained using a specific type of implant and will only use that implant.
   (a) This dynamic makes it so that math isn't the hard part anymore, the relationships people form can be the major barrier.
2) Balanced billing is not legal in Medicare, which is a barrier.
3) What happens if the price in the bundle is wrong?
   (a) That goes towards administrative burden. In addition to cutting prices, the administrative burden of providing info to CMS is prohibitive.
   (b) EHRs don't just spit out information like people assume they will and it takes a lot of time and money to comply with what the entities are asking for.
4) If it's not procedural based, payment mechanisms tend to work better when the unit of payment is based on the person rather than the condition.
5) A sticking point is how it seems easier in the bundle payments for certain things, but wonder whether or not we have the right metrics in place and are directing attention to one place and ignoring another over there. We're trying to move behavior in a certain direction, but what about everything else in the bigger picture?
   (a) You need to have population health to see the improvement to the community over the long course. This makes it very complex because there are things that are not controllable.
   (b) Need to make sure you are picking the right metrics to determine outcomes.
   (c) Over the next 10 years, I think there will be a vast sophistication on the measures for the population as a whole and metrics individualized to the patient that can be aggregated. Right now, we're really bad at this and patient experience is the worse metric by a long shot.
6) With respect to metrics, Temple Grandin at CSU has a lot of theorizing about how you handle metrics when facing a very long check list (i.e. over 100 metrics to look at). If you have a lot of

metrics, everyone ignores them all and you can get a good grade based on a few metrics that are easy to pull out, but it isn't actually comprehensive overall.

7) With bundling, the focus is entirely on price. Current technology in the employer market place is around 5 or 6 specific procedures. It is important to talk about how this effects the consumer and consumer preference, however with respect to the market it is all about cost.
8) What level of quality do you choose for what time period? How do you avoid plans pushing off treatment because the plan believes the patient will move to a new plan in the near future?
   (a) There are organizations trying to construct economic solutions to those types of issues.
9) Don't agree that capitation improves quality. I view capitation as purely a financial model to incentivize a practitioner to limit care. It dis-aligns incentives.
10) We haven't brought up the complexity of payment system and how we get paid from Medicare programs. If we just blended in-patient and out-patient rates, we could simplify and carve out so much cost as to be meaningful. For example, a patient shows up in ER and you get paid one way for in-patient treatment vs. one way for out-patient services. Services delivered to patients aren't any different, just about payment classification system. We could do away with cottage industries that come up after the fact that are costing unimaginable amounts to the rest of us.
   (a) You're talking about Side Neutral Payment which is a very hot topic right now.
   (b) Something to consider is the difference in facilities where services are rendered and how they are regulated. Regulatory burdens need to be recognized in the payment system as well.
11) It seems the Commission should be mindful of what incentive structures are out there, or how to prevent providers and payers from moving people completely off their caseload if the patient doesn't make them look good.
   (a) This goes towards risk adjustment methodology where you need to take all sides into account. Another areas is lack of ability to adjust for circumstances that may occur in certain situations.
12) There is a lot of work on effective capitation as an incentive structure. Capitated systems are not always the best systems to migrate towards. You want a mixed payment system where some things should be a flat payment combined with other payments structures that are more flexible.
   (a) We should pay close attention to balancing measures including patient satisfaction and outcomes.
13) Commission should be mindful of the difference in markets between rural and urban areas, it is difficult to incentivize a mom and pop shop with different payment forms.
   (a) That is a whole different situation. Models like these only work in free market situations and if you only have one provider in the area, it doesn't work.

C) Questions for Commission members to think about – we will have another discussion on this topic at the next meeting. What we've heard today is:
1) The current system is largely based on Fee for Service and there are questions about supply induced demand.
2) There are many payment experiments out there but with mixed reviews and results so they require more studying.
3) We need more thought around balancing measures and quality.
4) Where we end up may be a mosaic of several types of systems and may take time to see how they play out.

III) Public Comment

A) Ellen Caruso (via readytalk): There is worry from some providers around bundling payments.
B) George Swan, retired hospital administrator: My bill from a three day stay at the hospital was $260,000. I asked for an itemized bill and it turns out five drugs accounted for $233,000 of the bill –

Chemo drugs are very expensive. What was even more fascinating after the receiving the final bill, is that Kaiser's contractual adjustment was three percent and they ended up writing off $250,000 of the bill. These numbers unless you have a grip on them are hard to come by. I downloaded a dataset from CMS of the different hospital DRGs across the country and their payments. Colorado is a 96 percent state compared to the U.S. average. St. Joe, where I was treated, is a 19 percent premium hospital in Colorado. The recommendation I would have for you to consider is to introduce a reference price and pay the reference price paid. This was proposed in the 208 Commission. Reference price indexing is a biggie to consider bringing into data transparency.

IV) Review of Transparency and Work Force Recommendations – Commissioners

A) **Commission discussion on Transparency Recommendations:**

1) Pharmaceutical transparency is not included in the recommendations.
   (a) There are many states working on legislation in this area. This also probably belongs in the market conversation that we can include when we get to that topic area.
   (b) I would second comments about pharmaceutical industry and costs. It's interesting that in some instances doctors don't really know what is available. Many times they just prescribe what they are familiar with instead of what is available or more reasonable for the patient.
   (c) Second to rate increases, specialty drug costs are a number one concern from consumers. Insurance companies have issues negotiating with companies to get good rates and the bigger they are, the better they can do.
   (d) I would suggest that we somehow get more specifics on year over year pharmaceutical price increases so we can have a specific discussion with the group.
   (e) We will discuss with staff how to accurately include this into recommendations.
      (i) It should be included in both transparency recommendations and part of the markets topic area discussion.
2) In transparency recommendation list (sixth bullet) it uses the word "liability" and I think of this as medical malpractice; this should be revised.
   (a) Agreement wording should be changed in the bullet.
3) The second-to-last bullet in the parking lot should be moved to recommendations
   (a) We should move away from terms like "quality" and use things more like value based pricing.
   (b) There is work that still needs to be done on this idea and should remain in the parking lot at this time.
4) Wording for the APCD recommendation is strong and should be softened
5) The state of Utah is looking at hospital costs and are building a code system to track code and figure out on a per minute basis how much it costs to use every single piece of hospital stays. We should put this on the table because it seems Utah has actually seen some results and are getting lots of attention for this work. This seems like the kind of thing the Commission should be following.
   (a) This wouldn't be done in time for November report, but could be looked at to include in a future report.

B) **Commission discussion on Workforce Recommendations:**

1) It's striking we don't have anything about community health work or lower level workers coming up. This is a significant part of the SIM grant and capturing entire workforce arena.
   (a) When we use "health care professionals" it is meant to be broader and include all those you are talking about, but we can include more description on how to relay who all this includes.
2) The background section makes a lot of comments about specialty care data but it doesn't maintain the primary comment which is that Colorado has a Primary Care Provider shortage.

3) Changing payments to adequately fund primary care is in the parking lot and should work its way into recommendations
   (a) It was placed into parking lot because it was thought it would be discussed in the payment and delivery reform discussion. Perhaps it is important enough to recommend in both topic areas?
   (b) We need to be careful this doesn't move towards paying providers just based on what their practice level is, opposed to service provided.

V) Public Comment:

A) George Swan: Data transparency is correlated to pivot tables. Need recommendation that is something like, create pivot tables for easier more effective community stakeholder collaboration. There is an abundant number of pivot tables for you to look at now and hope this starts to get imbedded.
   1) You come to every meeting and are very passionate about pivot tables. When I talk about transparency, I think pivot tables are one tool in the toolbox to be used within that topic area. I think pivot tables are one piece of the spectrum, but a single recommendation on pivot tables may be a little strong as a recommendation on its own.

B) Chet Seward, Colorado Medical Society: You really are talking about making investments. You know, with regard to Medicaid parity rate decreases magnify the importance of the issue for the Medical Society. Our board voted this as the top issue of the organization. They want to move towards improvements starting with focus on Medicaid.

VI) Updates – Bill Lindsay/ Commissioners

A) November report draft
   1) We will circulate the draft report to Commission members next week and would like Commissioners to submit written comments to Lorez for the planning committee to then process and include in report, as appropriate.
   2) The report will be visionary and process oriented, it won't get into the granular details we are currently working on here.

B) Milliman Physical Therapy/Rehab report
   1) The draft report from Milliman on Physical Therapy and Rehab will be completed soon and will be shared with Commissioners before including in November report.
   2) We would like to have a discussion at the next meeting with a presentation from Milliman on any questions we might have on the report.

C) Reminder to Commissioners: The next few Commission meetings are very important and we ask everyone to be as involved as possible in the next month leading up to the completion of the November report.